

~~EMERGENCY TRAVEL PLAN~~

CLAIM FORM

EXPLANATION OF COVERAGE

The Emergency Travel Plan is intended to minimize the financial burden on the purchaser of the plan in the event of the death or very serious illness of a relative or other named person. The company will pay the transportation cost of the purchaser or designated person (See Definition Below) from the place of assignment or wherever the purchaser may be located on official duty to the location where the purchaser's attendance is required as a result of the very serious illness or death of a named person and return, subject to a maximum of \$1500.00. In the event of a paid claim the coverage under this policy will terminate and the total premium shall be fully earned.

INSTRUCTIONS:

- (1) The purchaser should receive one claim form for each named person.
- (2) Upon receipt of this claim form the purchaser should send it immediately to the named person or another person selected by the purchaser to act for the named person.
- (3) In the event of death or very serious illness resulting in a claim under this contract, this form must be completed and forwarded immediately to the [REDACTED]. This form may be used for immediate mailing by following instructions printed hereon; However, telegraphic or telephonic notice to the Insurance Company giving the information required will suffice, providing that, subsequently, this claim form will be completed and submitted to the Insurance Company.
- (4) The form below must be completed in full and signed by the attending physician.

DEFINITION
(Very Serious Illness)

A medical condition which by customary practice of the medical profession in the country in which such medical condition is diagnosed or treated is considered such as to warrant placing the patient on the critical list and such as to warrant a recommendation by the physician that the purchaser should be in attendance.

---To be Completed and Mailed by Physician---

NAME OF PERSON VERY SERIOUSLY ILL

WHERE LOCATED

NATURE OF ILLNESS

DIAGNOSIS, PROGNOSIS AND LIFE EXPECTANCY

I hereby certify that to the best of my knowledge and belief, the person named in this report is very seriously ill and that the presence of is recommended.

NAME OF ATTENDING PHYSICIAN _____

ADDRESS _____

TELEPHONE NUMBER _____

Physician's Signature

DATE _____

DISCHARGE PLAN

CASE NUMBER

NAME OF PERSON DISCHARGED

WHERE LOCATED

NAME OF ATTENDING PHYSICIAN

ADDRESS

TELEPHONE NUMBER

DATE

Physician's Signature